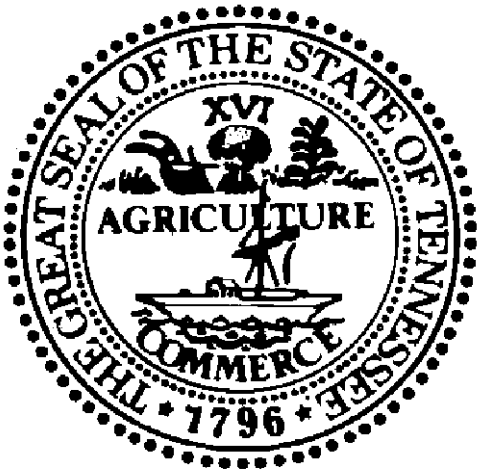

State of Tennessee

Department of Health

Tennessee Board of Social Worker Licensure

665 Mainstream Drive
Nashville, TN 37243

1-800-778-4123 ext. 741-5735
(615) 741-5735
http://www.tn.gov/health/

Applications and Procedures for

LICENSED CLINICAL SOCIAL WORKER

No members of any other mental health or medical discipline will qualify as an approved supervisor for L.C.S.W. or L.A.P.S.W. licensure.

Conflict of Interest Supervision - Supervision provided by the applicant's parents, spouse, former spouse, siblings, children, cousins, in-laws (present or former), step-children, grandparents, grandchildren, aunts, uncles, employees, or anyone sharing the same household shall not be acceptable toward fulfillment of licensure requirements. For the purposes of this rule, a supervisor shall not be considered an employee of the applicant, if the only compensation received by the supervisor consists of payment for actual supervisory hours.

GENERAL INFORMATION

It is the applicant's responsibility to review the current Rules and Laws for Social Work. To determine if you meet the qualifications for licensure. You may obtain a copy by going to http://tn.gov/health/topic/sw-board.

Individuals who do not qualify for licensure at this time are encouraged to complete deficient requirements if you intend to practice as a social worker in Tennessee.

It is the applicant's responsibility to keep the board notified whenever a change of name or mailing address occurs. Such notification must be in writing and you must reference your profession and the board in your correspondence. Supporting documentation and written request for a name change must state the reason for the change, i.e., marriage, divorce, etc .

Every effort is made to keep you informed, **in writing**, of the status of your application and to process your application in a timely, efficient manner. Inquiries regarding the status of a file will be responded to in writing. **Please refrain from calling the board office to check on the status of your application. It generally takes 4-6 weeks to process an application.**

You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code. Ann. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

SECTION I

LICENSED CLINICAL SOCIAL WORKER BY EXAMINATION:

CHECK LIST FOR LICENSED CLINICAL SOCIAL WORK

You send	**You request others to send**
_____ Completed and signed application _____ Fees of $ 235.00 ($100.00 application fee plus $ 125.00 license fee plus $ 10.00 State regulatory fee) payable to: the Board of Social Worker Licensure _____ Passport-style photograph _____ Notarized Declaration of Citizenship form found at: http://tn.gov/assets/entities/health/attachments/PH-4183.pdf _____ Copy of Current LMSW renewal card _____ Professional Reference _____ Verification of Supervision _____ Verification of supervisor's six (6) hours of continuing education related to clinical supervision _____ Detailed supervision logs indicating 3000 clinical and 100 supervision hours. _____ Completed Mandatory Practitioner Profile Questionnaire http://tn.gov/assets/entities/health/attachments/PH-3585.pdf **(mail with the application)**	_____ Request that an official transcript be mailed from the educational institution at which you completed your master's degree in social work directly to the Board of Social Worker Licensure. _____ If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a social worker (or as any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s). _____ Criminal Background Check For instructions go to: http://www.tn.gov/health/topic/CBC-check

Note: At least sixty (60) of the one hundred (100) supervisor contact hours must be one-to-one supervision between the supervisor and supervisee; no more than forty (40) hours may be in a situation where the supervisor is working with no more that four (4) supervisees in a group setting.

SECTION II

LICENSED CLINICAL SOCIAL WORKER BY RECIPROCITY:

CHECK LIST FOR LICENSED CLINICAL SOCIAL WORK

You send	**You request others to send**
_____ Completed and signed application _____ Fees of $ 235.00 ($100.00 application fee plus $ 125.00 license fee plus $ 10.00 State regulatory fee) payable to: the Board of Social Worker Licensure _____ Passport-style photograph _____ Notarized Declaration of Citizenship form found at: http://tn.gov/assets/entities/health/attachments/PH-4183.pdf _____ A copy of the original State's law and rules, if available _____ Photocopy of the original license from the original state of licensure with applicants current license number, if available; and _____ Photocopy of the applicants current renewal certificate with the license number and expiration date _____ Completed Mandatory Practitioner Profile Questionnaire http://tn.gov/assets/entities/health/attachments/PH-3585.pdf (**mail with the application)**	_____ Request that an official transcript be mailed from the educational institution at which you completed your master's degree in social work directly to the Board of Social Worker Licensure. _____ If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a social worker (or as any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s). _____ Verification of applicant taking and passing the ASWB examination _____ Criminal Background Check For instructions go to: http://www.tn.gov/health/topic/CBC-check

NOTE: IF AN APPLICANT DOES NOT QUALIFY FOR LICENSURE BY RECIPROCITY, HE OR SHE MUST APPLY FOR LICENSURE BY EXAMINATION. IF DOCUMENTATION OF APPROPRIATE SUPERVISION MEETING THE REQUIREMENTS PURSUANT TO RULE 1365-01-.01 (A) OR BEFORE DECEMBER 31, 2010 PURSUANT TO RULE 1365-01-.04 (5) IS PROVIDED THE APPLICANT MAY NOT HAVE POSSESSED THE CREDENTIAL OF LICENSED MASTER SOCIAL WORKER IN THE STATE OF TENNESSEE PRIOR TO APPLICATION TO SIT FOR THE EXAMINATION.

ATTACH
PASSPORT TYPE
PHOTO HERE

Tennessee Board of Social Worker Licensure
665 Mainstream Drive
Nashville, TN 37243

615-741-5735 or 800-778-4123 ext. 741-5735
http://www.tn.gov/health/

FOR OFFICIAL USE ONLY

Application fee	46-001	$100
License fee	46-001	$125
State Reg fee	46-017	$ 10
		$235

LICENSED CLINICAL SOCIAL WORKER

Please Check One: _____ LCSW BY INITIAL/EXAM _____ LCSW BY RECIPROCITY

NAME: _____
(Last) (First) (Maiden/Middle)

NOTE: This name will be used to register you with the testing agency (ASWB) you will be required to present the original ASWB Authorization Letter and one currently valid, non-expired government-issued photo-bearing ID. (driver's license, military ID, passport, etc.) at the testing center. The name on your ID MUST match your name as it appears on your Authorization Letter. You will not be allowed to test and will forfeit your exam fee without the Authorization Letter and proper identification.

Current Home Mailing Address:

_____

_____

_____

Current Practice Address: *

_____

_____

_____

*If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.

Home Phone # (____) _____ Work Phone # (____) _____

E-Mail Address:_____

Do you wish to receive notifications, including renewal notification, from the Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. Yes _____ No _____

Social Security No. _____-_____-_____ Birth Date: _____/_____/_____

Race:_____ Gender: Female _____ Male _____ U.S. Citizen: Yes_____ No_____
All applicants must complete the Declaration of Citizenship form.

Entitled to Live and Work in the U.S. Yes ___ No___

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) Yes ____ No _____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.) Yes ____ No _____

Have you ever been known by any other names besides what is listed above? Yes ____ No _____
If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known:

_____

_____

Educational Information:

Name of College/University: _____

Address: _____

City: _____ State: _____ Zip: _____

Degree Received: _____ Date Conferred: ____/____/____

	YES	NO
Are you or have you ever been licensed in this profession in another state?	____	____
Are you or have you ever been licensed in any other profession in Tennessee or another state?	____	____

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED**. Additional pages may be added if necessary. Request that verification of licensure be submitted directly to the Board's Office from each state.

STATE	PROFESSION	LICENSE NUMBER	CURRENT STATUS

LICENSURE INFORMATION: RECIPROCITY APPLICANTS

Have you taken and passed the ASWB Clinical exam? YES: _____ NO: _____

If yes, please have the ASWB send a copy of your test scores.

Please complete your entire healthcare employment history starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

Company/ Employer:	Address: (City, and State)	Position:	Duties:	Dates From: Mo./Yr.	Dates To: Mo./Yr.

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made.
For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:

a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3. **"Minor Traffic Offense"** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. **"Illegal use of illicit or controlled substances"** means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	YES	NO
1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	_____	_____
2. Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety? If so, please list _____	_____	_____

(If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to be determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)

3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	_____	_____

	Yes	No
4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	_____	_____
5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	_____	_____
6. Have you ever held or applied for a license, privilege, registration or certificate to practice social work in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
7. Have you ever held or applied for a license, privilege, registration or certificate to practice social work in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	_____	_____
9. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	_____	_____
10. Have you ever been rejected or censured by a professional association or society?	_____	_____
11. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered against you;	_____	_____
b. Have you ever entered into any settlement of any legal action; or	_____	_____
c. Are there any legal actions pending against you or to which you are a party?	_____	_____
12. Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	_____	_____
13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	_____	_____

AFFIDAVIT AND RELEASE

I, _____ of_____ being duly sworn and identified as the person referred to in this application, attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a social worker in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a social worker.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.

_____ _____

SIGNATURE **DATE**

PROFESSIONAL REFERENCE ASSESSMENT
(Verification of Supervision)

THIS SECTION TO BE FILLED OUT BY APPLICANT:

License Number (LMSW) _____
Effective Date ____/____/____
Expiration Date ____/____/____

_____
Applicant's Name

I have applied to the Tennessee Board of Social Worker Licensure to become a licensed clinical social worker. Your assessment of my characteristics will enable the board to evaluate whether I meet their standards.

_____ _____
(Signature) (Date)

REMAINDER OF THIS FORM TO BE FILLED OUT BY SUPERVISOR .

1. Supervisor's Name: _____

Profession: _____ Educational Degree(s): _____

Business address (street/city/state/zip): _____

_____

Position Title: _____ Telephone: (_____) _____

2. Supervisor's License No.: _____ Licensing State: _____

Date Licensed: _____

Clinical experience: Yes ___ No ___ Number of years: _____

3. Recordkeeping: Dates of Supervision: from ____/____/____ to ____/____/____

Total number of months of supervision _____
Total weekly clinical contact hours _____
Total weekly supervisor-supervisee hours _____
Total weekly group supervisee-supervisor hours _____

1. Total clinical hours during supervision period _____
2. Total supervisor-supervisee hours during supervision period _____
3. Group supervisee-supervisor hours during supervision period _____

(Add #2 and #3) Total number hours of supervision _____

4. Nature of setting in which supervised practice took place:

_____

_____

5. Please rate the applicant on the following characteristics. Place a check mark in every category!

Characteristics	Outstanding	Above Average	Average	Below Average	Can Not Evaluate
Individual counseling skills					
Appropriate referral making					
Group counseling skills					
Personal integrity					
Consulting skills					
Insight into client's problems					
Ability to relate to co-workers					
Ability to be objective on the job					
Ethical conduct					
Concern for welfare of clients					
Sense of responsibility					
Recognition of own limits					
Supervisory abilities					
Ability to keep material confidential					

6. Explain any rating of below average, poor, or can not evaluate (use additional paper if necessary).

I certify that the information contained herein is an accurate account of my supervision of:

(Applicant Signature)

(Supervisor's Signature) (Date)

(Print Name of supervisor)

Return completed form to:

Board of Social Worker Licensure
665 Mainstream Drive
Nashville, TN 37243

This Form May Be Duplicated

Clinical Hours/Supervision Log

(In the space below, please document the nature of your clinical practice hours and supervision hours for the time logged. Please note the clinical hours worked do not need to total exactly 30 each week. Some weeks may be more, some less. This is normal.)

Subject of Supervision Sessions (Please circle): Theory / Technique / Termination / Diagnosis and Assessment / Self Analysis / Laws and Regulations / Individual Counseling Skills / Group Counseling Skills / Confidentiality / Ethics / Boundaries

_____ Individual Supervision _____ Group Supervision Date from: _____/____/_____ Date to: _____/____/_____
Time In: _______ Time Out: ___________ Total Supervision hours this session: ______

Supervision content:

Clinical hours content:

Clinical hours	Non-clinical hours	Total work hours

Subject of Supervision Sessions (Please circle): Theory / Technique / Termination / Diagnosis and Assessment / Self Analysis / Laws and Regulations / Individual Counseling Skills / Group Counseling Skills / Confidentiality / Ethics / Boundaries

_____ Individual Supervision _____ Group Supervision Date from: _____/____/_____ Date to: _____/____/_____
Time In: _______ Time Out: ___________ Total Supervision hours this session: ______

Supervision content:

Clinical hours content:

Clinical hours	Non-clinical hours	Total work hours

Subject of Supervision Sessions (Please circle): Theory / Technique / Termination / Diagnosis and Assessment / Self Analysis / Laws and Regulations / Individual Counseling Skills / Group Counseling Skills / Confidentiality / Ethics / Boundaries

_____ Individual Supervision _____ Group Supervision Date from: _____/____/_____ Date to: _____/____/_____
Time In: _______ Time Out: ___________ Total Supervision hours this session: ______

Supervision content:

Clinical hours content:

Clinical hours	Non-clinical hours	Total work hours

Total Supervision Hours: Individual _______ Group _______
Cumulative Supervision Hrs: Individual _______ Group _______

Total this page			
Cumulative total			

(Supervisor Signature) (Date) (Print Name) (LCSW/ or LAPSW #)

(Supervisee Signature) (Date) (Print Name) (LMSW#)

This form may be duplicated